MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 13, 2001
9:02 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM:
Assessing payment for hospital outpatient services in rural areas (Chantal Worzala)

P R O C E E D I N G S

DR. WILENSKY: Further comments?

Thank you.

Chantal, we'll have you do your presentation and then we'll review some of the recommendations that we were going to revisit this morning. But I think it makes sense to continue on with your section. Thank you.

DR. WORZALA: Before I start with my own presentation I just want to clarify one point. The study that was just described was not, in fact, mandated congressionally. The reason we did it early rather than late was there was so much discussion about how terrible this payment system was going to be, that we wanted to have some notion of an early warning system. We never thought that we were getting definitive results about the implications of the new payment system.

And hopefully, we will do a repetition of this, or someone will continue the work in the future.

On to the next presentation, I'm here to discuss the appropriateness of the outpatient PPS for rural hospitals. This analysis, however, does respond to a congressional mandate

and it will be a chapter in the June report. The policy question before us is the following: do rural hospitals face special circumstances that make the outpatient PPS inappropriate for them?

The reasoning behind asking this question is that if PPS pays hospitals based on average costs and if rural hospitals face circumstances beyond their control that result in systematically higher costs, then they may need special treatment under the payment system.

You'll recall that we discussed this question in March, and the next slide is a reminder of what we covered then. I don't intend to address any of these points in detail here, but of course I'm happy to answer your questions on them.

I presented you with findings that show some evidence of special circumstances for rural hospitals. For example, rural hospitals have a greater reliance on Medicare as a share of revenue, and within Medicare on outpatient services. This does lead to greater exposure to the financial risks that are inherent in a prospective payment system.

They also have limited administrative capacity and financial reserves hampering their adaptation to a new payment system. And finally, many rural hospitals are low volume, leading to higher unit costs and less ability to spread risk

across services.

However, there are serious limitations to the evidence that we can gather so far, including lack of real experience operating under the new payment system and also data issues with both costs and claims.

We noted that rural hospitals with 100 or fewer beds benefit from a hold harmless provision that limits their losses under the PPS through 2003. This policy does cover more than 80 percent of all rural hospitals.

Finally, in March, we discussed future policy options including maintaining the current policy, establishing a separate conversion factor, implementing a low volume adjustment, extending the hold harmless provision, and returning to cost-based payment.

The one piece of new information that I have for you today are the results of a cost function analysis which we undertook to explain the observed differences in unit costs among hospital types, and also to examine the cost volume relationship.

I want to begin with the caveats. First, this is fairly old data which suffers from the same data reliability and validity issues we have discussed previously. In particular, there has been documented undercoding of these claims

historically, which understand volume, which could be problematic in an analysis such as this. Also, there are difficulties matching the cost data to the claims.

Finally, we only have one year of data, which lowers our confidence in the findings, particularly regarding the low volume hospitals due to annual variability, both in costs and volumes.

Nevertheless, we went ahead and did the analysis, and I'll present the results from a model that includes only variables that affect payment. The results from a general model, that included more hospital and market characteristics did find a similar volume/cost relationship.

DR. ROWE: Chantal, would you add amongst the caveats the fact that the data are five years old and that perhaps things have changed?

DR. WORZALA: Yes. That was actually my first caveat.

DR. ROWE: More recent data were not available?

DR. WORZALA: We could have invested considerable resources in developing more current data, but given the issues with coding of claims and matching cost reports to outpatient claims data, we didn't think that the data would be any more reliable in a later year. So we thought we would put that off until we had real data from under the outpatient PPS. This is

the data that HCFA put together to create the payment system.

The model explains variation across hospitals and unit costs from Medicare outpatient services. Those costs are adjusted for service mix and differences in input prices using the wage index.

The independent variables were cubic expansion of an annual volume measure, which was the number of services, hold harmless status and critical access hospital status. Both the dependent variables and volume variables were in log form.

The next graph illustrates the volume cost relationship at low volumes. I want to be clear that this is a truncated graph and one of the issues here is that volumes range from we did have some hospitals under 100 services annually, which I decided to take out of the sample. And they went as high as 500,000. So this is a remarkable range and what I'm reporting for you are those less than 10,000 services.

The X axis on this graph is annual volume as number of services, and the Y axis shows the predicted adjusted unit cost relative to the mean adjusted unit costs for all hospitals. So this can be thought of as a percentage above or below the mean unit cost.

You can see that the graph shows higher unit costs at lower volume levels, as we might expect. I do want to note

that the values shown here on the Y axis do differ from those in your briefing papers, and the estimated differences are considerably higher in the corrected graph.

Hospitals reporting fewer than 2,000 services per year had adjusted unit costs at least 15 percent higher than the average. Approximately 10 percent of hospitals had volume of less than 2,000 services.

MR. HACKBARTH: What percentage of the rural hospitals would fall within this volume range? Is this the vast majority of them?

DR. WORZALA: Sixty percent, if you take the 7,000 services, which is where the curve meets the mean and then falls below it, about 60 percent of rural hospitals fall below that level.

MR. HACKBARTH: So considerable.

DR. WORZALA: So it definitely is tilted towards rural at the low ends. And it's 40 percent of all hospitals that fall below the 7,000 volume level.

We did find no statistically significant difference in adjusted unit costs for all urban hospitals, larger rural hospitals -- those with more than 100 beds -- and rural referral centers. They seem to exhibit the same relationship. And these hospitals are the reference group, which is the

bottom line on the chart.

However, rural hospitals with 100 or fewer beds had unit costs that were 2 percent above those of the reference group at any volume level, and this is the middle line of the chart. These higher cost hospitals do benefit from the hold harmless provision.

And finally, critical access hospitals have unit costs that were 7 percent above the reference group at any volume level. This is the top line.

Given that these cost data pre-date the critical access program here there's actually a benefit to using 1996 data. It does show that the high cost hospitals have chosen to convert to critical access hospital status and they will be paid on the cost basis in that program.

I want to emphasize that we shouldn't attach any importance to the 2 percent and the 7 percent, only to say that the small rural hospitals are slightly more expensive than the larger rural and the urban, and that the critical access hospitals seem to be a fair amount more expensive than the reference group.

So keeping in mind our caveats, the conclusion that I would draw from this is first, that volume clearly is an important factor, but there are other factors working for the

small rural hospitals and the critical access hospitals.

Second, it appears that the rural hospitals with the highest costs did convert to critical access hospitals and are now exempt from this payment system. The remaining rural hospitals, the small rural hospitals, have unit costs that are slightly higher than the urban and large rural hospitals after accounting for volume. Again, those hospitals do have a hold harmless protection at the moment.

So to summarize the evidence I presented in March and the results of this analysis, I would make three points. First, there is some evidence, I think, of systematically higher costs and unique circumstances facing rural hospitals and particularly the small rural hospitals. However, the evidence has serious limitations and we don't have any experience actually operating under the PPS. The cost data we have is old and suffers from other limitations. And finally, the existing hold harmless policy benefits those small rural hospitals that appear to be most vulnerable to the payment system.

So taken together, these points suggest a policy of what I call watchful waiting and I have drafted the following recommendation for you to consider. Do you want me to do the recommendation now, Gail?

DR. WILENSKY: Yes, why don't you just read it and then

we'll open it for discussion.

DR. WORZALA: In the short term, no outpatient payment adjustments for rural hospitals are needed beyond the current hold-harmless provision. The Secretary should revisit the issue when better information on hospitals' experience with the payment system is available.

DR. NEWHOUSE: Chantal, I have two kinds of comments on the technical side for the cost function, and then a comment on the draft recommendation or a question. First, I think there are really serious technical problems with trying to estimate a low volume adjustment. One of them, I agree with you that there's almost certainly some economies of scale. But if the conclusion of that is therefore we need to get to a low volume adjustment and we're actually going to write down how much more we're going to pay per unit of service based on volume, that's going to be really hard.

One of the things you pointed to, which is the year-to-year variability, and that's potentially estimable and fixable, although the current version of bias is toward showing economies of scale, as you've said. The other one, however, I think is really hard, that you didn't mention. That is I think the right way to do this has to be to take account of all the product lines of the hospital, not just a separate analysis of

the outpatient department. Because the issue is how the hospital has allocated its joint costs across product lines.

So that actually gets to also the low volume adjustment in the inpatient side. I think it's just a really hard problem. I think both of those low volume adjustments are hard. But I think the analysis ought to say that that conceptually is the right way to do it because the hospitals will be allocating their costs in different ways.

On the recommendation, I don't have any problem with the bottom line of the first sentence.

On the revisiting the issue when better information is available, what I wasn't clear about was what information was going to be available on the rural hospitals where the hold harmless provision was in effect. I mean, first of all, could one trust the data that were going to be submitted by them, given the fact that they were held harmless? In the same sense that the urbans were actually being paid on that basis?

Second, did you have in mind extrapolating from the urbans back to the rurals? And are there really enough urbans down at that small scale to do that? And then how did this play with the conversion to critical access?

I wasn't clear, I mean while it's kind of motherhood and apple pie to say to revisit when better information is

available, I guess it would be nice if we pointed to how we were going to learn something from this better information, a little more specific.

DR. WORZALA: I did try and point in that direction in some of the questions that I asked at the end of the chapter. In terms of data, the way that the payment system is operating, hospitals do operate under the PPS. They submit their claim, the claim is paid. The way the hold harmless policy works is that there is a determination made at the end of the year as to whether or not hospitals were paid as much under the PPS as they would have been paid under previous payment policy.

So we ought to be able to get data that tells us what they were paid for the PPS services and what they were paid as supplemental TOPS payments. So we can still extract their costs for the services, so that it would be the same data manipulation only we would have better coding to be able to map the costs to the claims and to know that volume has been counted accurately.

So in terms of constructing data, it would be the exact same data construction process and the hold harmless policy, in its implementation, should not get in the way of being able to tease that out.

DR. ROWE: Chantal, my question has to do with what I see

as an ambiguity here. It may really not be a problem, but maybe you can help me with the economics of this.

It seems to me there are two issues. One is size of hospitals. You're defining this as less than 100 beds, which is kind of a measure of the capacity of the hospital. Then the rest of this has to do with volume.

It seems to me that there might be a mixture there. There might be small hospitals of 99 beds that are very busy and very full and are really using their capacity very much. The costs there might be significantly different than in a 99-bed hospital that has 10 patients on average in the census and very few visitors to the outpatient unit.

So by saying these are the small hospitals and this dataset represents them and this is how they behave, it seems to me that it might be more informative to sort of say what is the relationship of cost per unit item in those hospitals that are operating at or near capacity or in a higher quintile, and those that are operating at the lower quintile.

I think it might be possible that the lower quintile ones are the ones we really are worried about and that we don't want them to disappear because it would be an access problem, et cetera. Maybe you can help me with that.

DR. WORZALA: It would be wonderful to have that kind of

data, but I think there are two reasons to be concerned about what you've termed the lower quintile. One is that they may really be the only access around. Or they may be simply duplicate capacity that ought to close. That's very difficult to know which of those two things are there.

The reason we used 100 or fewer beds is because that is a payment provision, so those are the hospitals that are currently getting 100 percent of hold harmless payments from the system. And I think, in some ways, I found these results reassuring in that the payment system does seem to distinguish between groups that are in fact different in their cost structures.

DR. ROWE: But you could take these hospitals and take the group that were between 50 and 100 beds, say, and then array them by the number of discharges per year, per bed or something. And then take one group of them that's up and one group of them that's down and look at this analysis. Would that be informative in any way?

DR. WORZALA: I think this is another issue that I've been struggling with and that needs more attention analytically, which is that why exactly are we using an inpatient capacity measure to may payment decisions for an outpatient payment system? I'm not sure, given the diversification that's

happening in the hospitals away from inpatient services apparently, particularly in rural settings, I'm just not sure that using the inpatient measures makes that much sense. We clearly use them for reasons of history and for reasons of convenience. It's something that's very simple to measure.

But I guess I have a question of whether or not doing what you suggest would tell me anything about their utilization of their outpatient capacity, which is what we really care about.

DR. ROWE: That's a good point. With respect to this variable that's what we care about.

DR. WORZALA: And I'm not sure anybody knows a comparable measure of outpatient capacity. What would that be, FTU working on outpatient services? Volume? It's very hard to measure outpatient capacity, I think.

DR. WAKEFIELD: Just a couple of comments on text and then straight to the recommendation. There are a couple of places in the text, and I'll give you my written suggestions for you to consider Chantal, where it seems to me there's a -- I don't want to say confusion between the concept of inefficiency and higher costs due to low volume, but where it almost seems that we're suggesting that when we see high cost due to low volume, it would come almost right up to the line of labeling that as inefficiency. I'm not an economist, but it seems like we might

almost be using those concepts interchangeably.

I'll share my text with you and you can take a look at it, if you'd be so kind, on that front. Because I think we need to be really clear about that.

DR. WORZALA: It certainly wasn't my intention.

DR. WAKEFIELD: I didn't think so, but I just wanted to highlight that.

Second, I've got a question that probably Joe or Gail could answer this, or maybe you could, too, Chantal. And then I'm going to go to the recommendation. Is it likely that with outlier payments for outpatient PPS that they could conceivably have a more negative impact on rural hospitals in that outliers amounts are subtracted from those base payments. And to the extent that you may not see much in the way of outlier cases in rural hospitals that overall there could be a negative impact on rural hospitals given the extent to which they do it on outlier payments?

The reason I ask that question is because the issue of outlier payments is discussed on page five. So I just had a question.

DR. WILENSKY: It will lower the base, presumably it's lowering the base in an appropriate way to pick up the fact that you have these extreme cases and, to the extent that some

rural hospitals will indeed have outliers, they would probably be the least able to cope with these outliers.

DR. NEWHOUSE: The thing about the inpatient side, I mean you could make the same argument on the inpatient side, but in the large urban hospitals where you get the outliers, that's where you're having the costs of these cases. And the pot of money, it's a question of how you send the pot of money around to different hospitals. And you're trying to send it to where the costs are.

DR. WAKEFIELD: Then your point, Gail, about those cases for very small hospitals where you do see one or two outliers, you're saying in that case that comes back in.

DR. WILENSKY: There's a reason outlier payments are really important when you have a system of averages. And to some extent you could say they're more important in small or low volume hospitals because you could more or less incorporate the variation that you might see. That's a somewhat extreme case but you are less likely of it being able to tolerate random hits.

DR. WAKEFIELD: Thanks for that explanation.

With regard to the draft recommendation, I'm a little bit concerned mostly about the first sentence in terms of its wording, that in the short term no adjustments for rurals are

needed beyond the current hold harmless provision.

Let me step back and comment directly on the recommendation. The first sentence, I'm concerned about the fact that there seemed to be some cash flow problems that I've heard from rural hospitals specifically. There are clearly some problems with changes in inpatient copay to beneficiaries in rural areas. It's also a fallout of this new system.

And I'm concerned that we've still got data problems. My concerns aren't alleviated much by the earlier presentation that preceded yours, that we're going to have data that will have been collected, analyzed, and that HCFA is able to react to, and that rural facilities will be able to comment on between now and when this hold harmless is lifted.

So I'm concerned about our saying that there are no outpatient payment adjustments for rural hospitals needed beyond the current hold harmless provision. I don't know that we know that to be the case. I don't think we know much, I guess is what I'm saying at this point in time.

DR. WILENSKY: Let me just try and make sure I'm clear about what you're saying. We clearly know what we know and in the short term we don't know very much about the outpatient PPS for rural or urban hospitals.

But my sense is either we have a recommendation that we

make about what we think should be done with outpatient or we think that in the interim -- I mean, I'm assuming the short term is really this interim period -- is there a different recommendation that you would want to propose that we make for rural outpatient now, other than to say that for the next year-and-a-half, roughly the period in which we're covering because you have to get ready for whatever you're going to -- next year we would have to be in a position to say following 2003 here's what we want to have happen.

So really the question is do you have a recommendation that you want the commission to consider as to what we propose now, between now and 2002?

DR. WAKEFIELD: Yes, I'm not sure we're giving the hospitals themselves or HCFA adequate time to accumulate information that's needed to understand the impact of this PPS on small rural hospitals and then to react to that information. So I guess what I'd be asking for at least a transition after 2003. I'm just concerned that by 2003, that hold harmless drops off sharply and those outpatient facilities get what they get.

DR. NEWHOUSE: Let me suggest a change, what I think has the same substance but may be a change in tone that addresses your issue, which is something like, current information is

inadequate to suggest a change in the hold harmless provision. Leaving open the possibility that information may accumulate downstream that would suggest a change. But we don't have any basis for doing anything at the moment.

DR. WAKEFIELD: We don't.

DR. WILENSKY: And next year, we could presumably make a recommendation in 2002 that when the period ends that we transition rather than drop in one year. I'm not sure that that's particularly a 2001 recommendation but we can consider it.

MR. DeBUSK: Chantal addressed what I was concerned with. I think the recommendation looks pretty good the way it is. Until you collect some data, and if you're being held harmless and we're running a prospective payment system over the next several months prior to the deadline, surely out of that -- and we have two years that we can come up with just what the actual performance is. I mean, you're going to have real data instead of '96 data. Surely we can look at that and make a decision.

If these hospitals with the low -- I mean, it's a volume issue. That's what it all comes down to. If there's some provisions that's going to be needed to be made in order to compensate these people more in the rural areas, looks like we could do that in the last year or so prior to the expiration of

this period.

DR. WILENSKY: I think we'll be in a much better position a year from now to know whether we think -- what kind of a recommendation we ought to make rather than two years out. I'm not sure whether we'll have the information or not, and we certainly historically have recommended transitions, although I don't know whether this is the same magnitude of change that usually recommend a transition. But transitions have been a frequent recommendation of this and predecessor commissions, so there's certainly a lot of precedent for it.

MR. DeBUSK: There's a whole new coding system that went into law last year that's not even rolled out yet with the outpatient piece, and there's a new revenue stream, that's not even been addressed. I won't go into that today, but there's a lot of things to happen yet before --

DR. WILENSKY: There's clearly a lot we don't know.

DR. STOWERS: The only problem I had with the recommendation is the word beyond. Do we mean in addition to?

DR. NEWHOUSE: Yes.

DR. STOWERS: Because we very easily here could send the message to Congress that at the end of 2003 or whatever, that it shouldn't go beyond that.

DR. WILENSKY: No, that was not -- in addition to is

clearer.

DR. STOWERS: So I would make that change.

DR. BRAUN: I had a little problem with the text on page 10, and because it changes the meaning a little bit I thought we needed to bring it up rather than just letting you know. It seems to me that the section under unique social role, that we're saying something that we don't ordinarily believe in. As a matter of public policy we may wish to pay more for services provided in rural hospitals, not only due to higher cost but because they serve other important functions that we're willing to subsidize through higher payments.

DR. WILENSKY: I think that's actually a good point. I think at the most we can say that it's been argued that. We as a commission have certainly not bought into that.

DR. BRAUN: But I think we could probably reword that so it sounds something like, as a matter of public policy we may wish to emphasize the need for adequate payment, and then in the latter part say, serve other important functions whose continuance we're willing to assure through higher payments. I think that would give the emphasis to the social role but won't say what we don't want to say.

DR. NEWHOUSE: This isn't the only place in this report that the social role comes up. I personally agree with Gail,

that we should be agnostic as a commission on that.

DR. WILENSKY: I think we have very clearly indicated our concern that seniors be able to get access to affordable health care. If that means paying more, and low volume impact on cost suggests that it would mean paying more for certain kinds of hospitals or cost-based systems for critical access hospitals, et cetera, I think we're all comfortable that that's what it will take to get -- if that's what it takes to get seniors access to high quality care, that that's something that we're comfortable recommending.

I don't think that this commission has had that discussion about whether we would be willing to recommend higher payments so that economic development can occur in a rural area, and I don't think that's the function for this commission. So I think we ought to in general go through the report to make sure that we are not seen as advocating that position. Again, that's certainly a position that other people have advocated but I don't think it's our --

DR. ROWE: It's interesting that yesterday much of the discussion with respect to rural hospitals in the area of payment had to do with margins; talking about inpatient margins, total Medicare margins, total hospital margins. This discussion is primarily about cost. It's not about margins.

I wonder whether or not it might be appropriate or helpful to bring in at least the concept of margin. That is, if we're going to be thinking about making adjustments, it shouldn't be just based on a relationship of volume and cost, but as you were saying yesterday, getting the Medicare payments right. It might be interesting to look at that issue.

DR. WILENSKY: One of the difficulties, obviously, with this area is that there has been some high degree of skepticism as to whether or not -- Bob was, I gather, going to say the same thing -- it's true for inpatient, but the inpatient is such a big number with so much stuff in it, you get a little less worried. With the outpatient, since we have had strong suspicions that it has been the recipient of many charges over the years, because of the incentives that we set up, that looking at margins for the outpatient may tell you many things, but not clearly the financial health of the outpatient.

DR. REISCHAUER: Which is underscored by Chantal's Table 3 where all hospitals have negative outpatient margins. It's sort of like, why do you want to be in this business at all? Are you really dumb?

DR. ROWE: Absolutely.

DR. WILENSKY: So I think at some point if we believe the numbers have a chance to work their way through so that you get

back to a better distribution -- in principle you're absolutely right, that's a good idea. But when you have this small sector which has been, we believe, the recipient of lots of charges that are not outpatient, you really have funny numbers. So I just don't know that you end up feeling you want to make decisions based on these numbers. It truly is hard to believe that these are real.

DR. NEWHOUSE: It goes back to the point the hospital really isn't separable in the way that we're trying to treat it as separable.

DR. WILENSKY: Why don't we return now to the recommendation and think about some of the wording change, and the issue that Mary raised about whether this year we want to go further. There's at least a couple sense -- one is, are we as a commission comfortable saying that for right now we are not recommending a change in terms of payment in addition to the hold harmless. That's the first question.

The second concept is, while we may find ourselves a year from now uncomfortable that we understand the effect on rural hospitals, or that we may want to make a recommendation for transition as happened late in the game with regard to physician payment when we were getting ready to go to the practice expense and thinking about transitions, or whether you

think it's important to make that statement now.

And then any other wording change. Ray had suggested the term, in addition, rather than beyond, to clarify and I think that makes it clearer what we mean. So the first is, are people comfortable with that first statement with that change?

Okay. I don't have a problem with the second statement. I think the real question at a substantive level is, is that okay? Then the additional question is, do we want to make an additional recommendation at this point or do we want to revisit this in a year? Because I think we definitely need to consider the issues of what we know a year from now and what that leads us to recommend as they get ready to hit that 2003 transition.

DR. STOWERS: My only question is whether, or maybe we're not wanting to come right out and say that we think the hold harmless ought to continue until there is adequate data available to show that we will not have an access problem, or are we just inferring here that we're going to continue over the next couple of years before it expires? I just think maybe Congress is waiting for a message, should we extend this thing further, should we cut it off?

DR. WILENSKY: I think that's really the reason for the second question. To be perfectly honest, saying that does not

send exactly the right signal about getting more information. So I think there is a problem. If you say, we're going to continue hold harmless until we are sure we have the data to suggest to go otherwise, you don't -- I mean, what we'd like to do is have enough information we feel comfortable.

Now I think it is certainly consistent with past recommendations. A year from now we will say, we ought to start transitioning unless we know something that we don't know now. I think that's certainly a very consistent recommendation. A year from now we might decide we really don't know enough and that an additional year is appropriate. I just get a little nervous about that we'll--

DR. STOWERS: I'm okay with that.

DR. REISCHAUER: I think also we should hold open the option that if we speak on this in the future we might be speaking in a very different way. What Chantal's information suggests is that urban hospitals with low volume of services have higher costs as well, and you might want to have a volume adjustment for all kinds of hospitals rather than just these less than 100 bed hospitals in rural areas.

DR. WILENSKY: Or not.

DR. NEWHOUSE: Or not, say if there's a hospital across the street.

DR. REISCHAUER: Or not for have it anybody, right. But what I'm saying is there's a lot of different dimensions we'd want to look at.

DR. WILENSKY: Yes. So I would say, and in the text it's certainly appropriate to indicate that there are a lot of unknowns and we're concerned about it, and issues of transitions are appropriate concerns, issues of whether or not there's a need for a low volume adjustment for hospitals with under 100 beds and that are serving a special function is an issue that ought to be taken up when we have more information. But to leave that door open I think at this point, that would be my preference.

DR. WAKEFIELD: I agree with you, Gail, I think that's fine and a good discussion of the framing in the narrative that accompanies that. And low volume related to isolated providers, getting at Joe's point. We're not interested in erecting a barrier that's going to protect everybody everywhere.

So I think to the extent we can reflect those notions in the text that accompanies this, but fundamentally saying, we just don't know enough right now, we don't know enough to say that in 2003 this ought to be ended or it ought to be continued. But people have got to pay attention to this. It

seems to me if that's the tone, that would be great.

DR. WILENSKY: Yes, and especially in isolated.

Let's go down the recommendation. All those voting yes?

All those voting no?

All those not voting?

Thank you, Chantal.

MR. HACKBARTH: Could I just go back to the discussion we just had about margins and just help me think this through? We're saying that because of cost allocation in the past that the outpatient negative margin is probably not an accurate reflection of actual performance. I guess it also follows from that, however, that the inpatient margins are overstated, but given the relative size, the effect on the inpatient would be smaller.

But if we're talking about rural hospitals where the outpatient is a bigger proportion, the distortion on the inpatient margins would be a more significant issue. If in fact they've been over-allocating cost to the outpatient side, inflating the inpatient margins, and the outpatient is a larger share of their business, that means the overstatement of their inpatient margins is more of an issue.

DR. NEWHOUSE: But remember, a number of those hospitals have elements of cost reimbursement, so they don't have the

incentive to allocate in the same way.

DR. WILENSKY: It's just been so messy. The problem is, if we were comfortable that we knew what adjustments to make --

DR. ROWE: It urges looking at, if at all, at the overall Medicare margins.

DR. WILENSKY: Yes, absolutely.

DR. ROWE: Then you're not trying to chase the allocation --

DR. NEWHOUSE: That's my point.

DR. ROWE: That's the one piece that wasn't on those slides. We got inpatient Medicare margin, and overall hospital margin, but not overall Medicare margin.

DR. WILENSKY: I agree, and I think that in continuing to look at the issue, the total Medicare margin is at least as important as the total margin.

DR. ROWE: That's going to be more helpful in follow up, because what's going to happen in response to these policy changes in the outpatient PPS rather than cost based, whatever, is presumably they're going to stop over-allocating a lot of this stuff to the outpatient, driving up the outpatient cost base, and that shift would screw up the data except that if you continue to look at overall Medicare margins.

DR. WILENSKY: Murray has reminded me that we do get into

an additional data problem because we tend to have inpatient Medicare and total margins first, and mostly Medicare or the total Medicare margin comes in somewhat second timewise. But you're absolutely right, and I think we have to be careful when we're talking about appropriate Medicare policy. I believe, and I think it's been consistent with the position of the Commission that we want to make sure Medicare is doing the right thing.

Now to the extent that we are having a little help or a little harm from the private sector, it's not that we should completely ignore it, because completely ignoring it could mean access problems for the seniors, and that's an issue. But we also have said we don't really want to get in the business of either making up for bad decisions that hospitals make in the private sector, or necessarily penalizing hospitals because of some favorable conditions they have with the private sector.

So I think it's fair to say, total margins are relevant because total margins have something to say about access. Medicare may be doing its share, but if the hospital is going down the tubes that's going to -- if there aren't other hospitals around, that will impact access for seniors, so we can't ignore it.

But I think our primary focus ought to be on the Medicare

margin and the total margin. It maybe either to have less -- if we ever get to a steady state, that the inpatient-outpatient issue becomes less important. But as long as payments are geared to inpatient-outpatient, obviously they'll still have their own importance.

DR. ROWE: Can we address this lag or latency with respect to the data? Is there a way to get the outpatient data more promptly so we have the total margins?

DR. WILENSKY: I can't speak to -- that's definitely beyond my pay grade.

DR. ROSS: I can't speak to the specifics but that's been a continuing battle of all the things, relying on different data sources. We're trying to get the early indicators on the total margin data from our hospital indicator survey that we sponsor with HCFA, and then bringing in the cost reports, and then doing the construction of bringing in the other services.

DR. WILENSKY: At some point this new AHA dataset I thought was supposed to make many of these issues more tolerable, but I gather not? Not yet.

MR. ASHBY: Let me just comment on that. The inpatient margin, the outpatient margin, the total Medicare and the total margin are all on the same schedule, about a two-year lag. But we do have our separate survey that we have cosponsored with

HCFA that gives us a total margin on a very short turnaround.

DR. ROWE: For Medicare or total?

MR. ASHBY: No, total, grand total margin, on less than a six-month turnaround, which I think puts us in a really terrific situation to monitor the overall financial health of the industry. But beyond that, all of the margins are on the same schedule and we have that unfortunate roughly two-year lag.

DR. NEWHOUSE: You don't want to get carried away with the be-all and end-all of Medicare. That margin reflects how the hospital has accounted for allocating its cost between payers and among payers, and it reflects its payer mix.

DR. ROWE: That's why you need both, Medicare and total margins.

DR. WILENSKY: You weren't arguing against though. You were saying --

DR. NEWHOUSE: That's right. I agree with this, we do need them.

DR. ROWE: I was arguing for the Medicare total margin to get around this cost allocation, inpatient-outpatient problem.

DR. WILENSKY: I think we would be better informed to have a column that says total Medicare margin, or the closest approximation to the total Medicare that we can get.

MR. ASHBY: If we're talking about doing that now for the June report --

DR. WILENSKY: No, we're obviously not. We understand. We're not talking about it now for the June report.

MR. ASHBY: Because there's a slight difference in getting that total Medicare margin. It takes a special run from HCFA.

DR. WILENSKY: We felt like we knew enough about what the total Medicare numbers were looking like that we could mentally put the column out there. But in the future it would be helpful to actually be looking at the difference between the inpatient or outpatient Medicare, the total Medicare, and the total margins so that we could see both Medicare's impact and the financial health of the hospital at the same time. Especially because it turns out that it's very different in general in urban versus rural, or especially large urban versus rural in terms of who's playing what cross-subsidizing role.

DR. WAKEFIELD: And how much work rural hospitals, for example, do in the outpatient setting site.

DR. WILENSKY: And the different mix; different mix between inpatient and outpatient, and where the relative margins are high between Medicare and the private payer. That's just so different that it makes it hard to not have that.

Why don't we revisit our --

DR. ROSS: Labor share, home care data, and the buy-in.

DR. WILENSKY: Who has the wording? We have three recommendations we wanted to revisit.

MR. PETTENGILL: Except for the word carefully, this is the recommendation you approved yesterday. This is the proposed alternative.

DR. WILENSKY: Do you want to flip up again where we started from? This was looking at -- what we had approved yesterday minus the carefully was, examining the costs included in the labor share to ensure that each labor share only includes costs for resources purchased in the local markets. The suggested revision is what we just had distributed.

MR. PETTENGILL: This puts the emphasis on whether it's local or national rather than --

DR. WILENSKY: Okay. Voting for?

Voting again?

Not voting?

Done. Thank you.

There were two other revised recommendations, one on home health and one on access.

MS. ZAWISTOWICH: I think the quality one we resolved yesterday.

DR. WILENSKY: Okay. There was an access revision somebody was doing?

MS. MUTTI: This follows up from last night's discussion on the access chapter. We just changed the wording to --

DR. WILENSKY: Excuse me. Glenn, have you had a chance to see the revision that we just --

MR. HACKBARTH: Yes.

DR. WILENSKY: Go ahead.

MS. MUTTI: This one I didn't hand out to you; it's just up on the screen there. It's just reflecting that we're identifying strategies to increase beneficiaries participation and trying to make it clear that it's government programs that cover premiums --

DR. WILENSKY: I think that's fine.

DR. NEWHOUSE: Do we want to specifically say QMB, SLIMB? I mean, government programs could be read to include state government programs. I don't know that we mean to include that. Are there other federal programs beyond QMB, SLIMB?

DR. REISCHAUER: Federal programs?

DR. WILENSKY: QMB is federal/state, isn't it?

DR. NEWHOUSE: Are there other programs than QMB, SLIMB that we have in mind?

MS. MUTTI: Do you want to include dual eligibles?

DR. NEWHOUSE: If there aren't, it seems like that's what we ought to say.

MS. NEWPORT: Yesterday, the clarification, the question I asked was if this included Medigap, Med supp programs, and the answer was no.

DR. WILENSKY: That's a different issue. That's not encouraging them. These are encouraging people who --

DR. REISCHAUER: This is dual eligibles, QMB, SLIMB.

DR. WILENSKY: I think in the recommendation we should leave it that way, and in the paragraph following indicate, these government programs include Medicaid, QMB, SLIMB --

MS. MUTTI: And the QIs. Do the full range.

DR. WILENSKY: There's something after SLIMB that's even more limited.

MS. MUTTI: For home health.

DR. WILENSKY: List the various government, but I don't think we need to put it in the recommendation, just to have the paragraph following it.

All voting yes?

All voting no?

All not voting?

Thank you.

MS. BEE: This recommendation is intended to address the

data needs we identified in our earlier discussion of whether or not to exempt rural home health. This is new language.

This recommendation reads, the Secretary should create a pool of home health providers for special study, to evaluate as soon as possible the rural impact of the PPS, to evaluate costs that may affect the adequacy of PPS payment, and to find ways to improve all cost reports.

In the text to support this we would add, the pool should include more rural providers than the pool used to build the PPS. We want to investigate the effects of travel and low volume, give special attention to isolated rural areas, and investigate differences in patterns of care, assess cost report burden issues, incentives, and the need for clarification.

DR. NEWHOUSE: In the discussion did we mean to limit this pool to rural home health agencies?

MS. BEE: No.

DR. WILENSKY: I could personally do without the, as soon as possible phrase, since I think that's somewhat gratuitous. Other than that I think the wording is fine.

DR. WAKEFIELD: You ticked what you were willing to put in, what you were thinking in the narrative. Will you also make some passing reference to isolated low volume?

MS. BEE: Okay.

DR. WILENSKY: In the discussion.

DR. NEWHOUSE: In those priorities that you laid out, did we come down on clarifying what they were supposed to report? That seemed to me to be important.

MS. BEE: Yes.

DR. WILENSKY: Any other comments?

All voting yes?

All voting no?

All not voting?

MR. HACKBARTH: Was there a vote on the revised labor share?

DR. WILENSKY: Yes.

MR. HACKBARTH: Could you show me as voting yes?